		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014076

Facility Name: Sunny Hill Skilled Rehab Ctr

Address: 421 Doris Avenue (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-8710 **Fax #** (815) 727-8637

IDPA ID Number: 366006672001

Date of Initial License for Current Owners: 1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2003 to 11/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	250	Intermediate (ICF)	250	91,500	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,950	770	6,448	11,168	8
9	SNF/PED					9
10	ICF	54,711	13,776	3,376	71,863	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,661	14,546	9,824	83,031	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.62%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 6,448

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: No tax year Fiscal Year: 11/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	672,133		15,069	687,202		687,202		687,202			1
2	Food Purchase		500,662		500,662		500,662	(2,190)	498,472			2
3	Housekeeping	1,001,389	75,863		1,077,252		1,077,252	(208,611)	868,641			3
4	Laundry			25,913	25,913		25,913	208,611	234,524			4
5	Heat and Other Utilities			213,520	213,520		213,520		213,520			5
6	Maintenance		183	96,135	96,318		96,318	504,100	600,418			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,673,522	576,708	350,637	2,600,867		2,600,867	501,910	3,102,777			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,892,585	441,725	852,066	7,186,376		7,186,376		7,186,376			10
10a	Therapy		10,660	594,491	605,151		605,151		605,151			10a
11	Activities	254,560			254,560		254,560		254,560			11
12	Social Services	217,118			217,118		217,118		217,118			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,364,263	452,385	1,446,557	8,263,205		8,263,205		8,263,205			16
	C. General Administration											
17	Administrative	76,392			76,392		76,392		76,392			17
18	Directors Fees											18
19	Professional Services			78,038	78,038		78,038	586,578	664,616			19
20	Dues, Fees, Subscriptions & Promotions			25,480	25,480		25,480	(195)	25,285			20
21	Clerical & General Office Expenses	336,803	17,435	35,816	390,054		390,054	22,640	412,694			21
22	Employee Benefits & Payroll Taxes			98,330	98,330		98,330	3,620,577	3,718,907			22
23	Inservice Training & Education			3,229	3,229		3,229		3,229			23
24	Travel and Seminar			423	423		423		423			24
25	Other Admin. Staff Transportation			935	935		935		935			25
26	Insurance-Prop.Liab.Malpractice							360,292	360,292			26
27	Other (specify):*											27
28	**TOTAL General Administration**	413,195	17,435	242,251	672,881		672,881	4,589,892	5,262,773			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,450,980	1,046,528	2,039,445	11,536,953		11,536,953	5,091,802	16,628,755			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr #0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			322,024	322,024		322,024		322,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,328	1,328		1,328	(1,328)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			82,488	82,488		82,488		82,488			35
36	Other (specify):*											36
37	**TOTAL Ownership**			405,840	405,840		405,840	(1,328)	404,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,372	10,504	278,876		278,876		278,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		268,372	175,204	443,576		443,576		443,576			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,450,980	1,314,900	2,620,489	12,386,369		12,386,369	5,090,474	17,476,843			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,190)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,328)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5a attached	(195)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (3,713)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,094,187		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 5,094,187		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 5,090,474		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/1/2003 to 11/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Chamber of Commerce dues	(195)	20
Total	(195)	

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr

ID# 0014076

Report Period Beginning: 12/1/2003

Ending: 11/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr **#** 0014076 **Report Period Beginning:** 12/01/2003 **Ending:** 11/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,190)	0	0	0	0	0	0	0	0	0	0	(2,190)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	504,100	0	0	0	0	0	0	0	0	0	504,100	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,190)	504,100	0	0	0	0	0	0	0	0	0	501,910	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	586,578	0	0	0	0	0	0	0	0	0	586,578	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	22,640	0	0	0	0	0	0	0	0	0	22,640	21
22	Employee Benefits & Payroll Taxes	0	3,620,577	0	0	0	0	0	0	0	0	0	3,620,577	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	360,292	0	0	0	0	0	0	0	0	0	360,292	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	4,590,087	0	0	0	0	0	0	0	0	0	4,590,087	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,190)	5,094,187	0	0	0	0	0	0	0	0	0	5,091,997	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/2003 **Ending:** 11/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,518)	5,094,187	0	0	0	0	0	0	0	0	0	5,090,669	45

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Will County	100.00	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional services	$	Will County	100.00%	$ 586,578	$ 586,578	1
2	V	21	Film processing		Will County	100.00%	22,640	22,640	2
3	V	22	Employee benefits		Will County	100.00%	3,620,577	3,620,577	3
4	V	26	Insurance		Will County	100.00%	360,292	360,292	4
5	V	6	Maintenance		Will County	100.00%	504,100	504,100	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 5,094,187	$ * 5,094,187	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	See attached list of	County board									4
5	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A	5
6	No services have been provided to the nursing home by board members.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 1/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Will County
Street Address: 302 North Chicago
City / State / Zip Code: Joliet IL 60432
Phone Number: (815) 740-4607
Fax Number: (815) 740-4319

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct cost	N/A	1	$ 504,100	$	1	$ 504,100	1
2	19	Professional services	Number of warrants	N/A	1	586,578		1	586,578	2
3	21	Film processing	Estimated time	N/A	1	22,640		1	22,640	3
4	22	Employee benefits	Direct cost	N/A	1	3,620,577		1	3,620,577	4
5	26	Insurance	Direct cost	N/A	1	360,292		1	360,292	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,094,187	$		$ 5,094,187	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Various		X	Finance charges							1,328	7
8												8
9	TOTAL Facility Related						$	$			$ 1,328	9
	B. Non-Facility Related*											
10												10
11								Less: non-allowable finance charges			(1,328)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,328)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

Not applicable - county does not pay real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Skilled Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - county does not pay real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 128,067 B. General Construction Type: Exterior Brick Frame Steel, concrete block Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	1,972		$ 25,000	1
2					2
3	TOTALS	1,972		$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1972	1972	$ 1,375,843	$ 34,396	40	$ 34,396	$	$ 1,129,334	4
5	150		1976	1976	1,198,083	29,952	40	29,952		853,632	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1970	727		20			727	9
10	Landscaping			1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance			1973	37,155		10-20			37,155	11
12	Door			1974	38,466		20			38,466	12
13	Asphalt Paving			1975	155,856		15			155,856	13
14	Landscaping			1976	57,254		10-15			57,254	14
15	Sewer and Water			1976	26,031	868	30	868		24,738	15
16	Plumbing			1972	183,817		25			183,817	16
17	Heating and Electrical			1972	522,443		20			522,443	17
18	Plumbing			1976	262,534		25			262,534	18
19	Heating and Electrical			1976	508,942		20			508,942	19
20	Sprinkler System and Paving			1975	83,460		25			83,460	20
21	Repairs / Roof			1981	107,858		15			107,858	21
22	Building Improvement			1987	819,813	32,792	25	32,792		573,862	22
23	Reroof A & B Rood			1985	85,920	4,296	20	4,296		83,772	23
24	Parking Lot Lights			1989	3,040		15			3,040	24
25	Reroof / Hot Water			1992	162,867	8,143	20	8,143		101,788	25
26	Washer Repair			1992	3,284		3			3,284	26
27	Site Improvements			1993	101,451	6,764	15	6,764		77,786	27
28	Laundry Renovation			1994	108,852	7,256	15	7,256		76,188	28
29	Paving Parking Lot			1995	66,260	4,417	15	4,417		41,961	29
30	Laundry, Air Conditioner			1996	362,815	30,235	12	30,235		256,997	30
31	Elevator Repair			1997	4,990	499	10	499		3,743	31
32	Tile			1992	7,040		5			7,040	32
33	Elevator Repair			1996	2,212		3			2,212	33
34	Sheeting			1993	3,685		3			3,685	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Site improvement	1998	$ 2,936	$ 294	10	$ 294	$	$ 1,911	37
38	Electrical work	1998	2,085	209	10	209		1,358	38
39	Plumbing repair	1998	2,440	244	10	244		1,586	39
40	Boiler repair	1998	4,273	427	10	427		2,776	40
41	Fence	1999	1,000	100	10	100		550	41
42	Air Conditioning Repair	1999	6,284	628	10	628		3,454	42
43	Boiler repair	1999	4,965	497	10	497		2,733	43
44	Doors	1999	4,842	484	10	484		2,662	44
45	Carpeting	1999	1,649	165	10	165		907	45
46	Nurses Station	1999	53,554	5,355	10	5,355		28,114	46
47	Wallpaper	2000	840	84	10	84		378	47
48	Vinyl Board	2000	823	82	10	82		369	48
49	Office Compressor	2000	1,205	120	10	120		540	49
50	Fire System	2000	3,441	344	10	344		1,548	50
51	Fence	2000	936	94	10	94		423	51
52	Air Ducts	2000	3,090	309	10	309		1,391	52
53	Service Work	2000	1,573	157	10	157		707	53
54	Parking Lot	2000	4,860	486	10	486		2,187	54
55	Circular Pumps	2000	1,079	108	10	108		486	55
56	Boiler repair	2001	5,326	533	10	533		1,865	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		2,940	58
59	Air Cleaner	2002	2,020	202	10	202		505	59
60	Boiler	2002	5,658	567	10	567		1,417	60
61	HVAC Control	2002	2,800	280	10	280		700	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		6,522	62
63	Doors	2002	4,155	416	10	416		1,040	63
64	Fireproof Framing	2002	2,730	273	10	273		683	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,504,680	$ 175,861		$ 175,861	$	$ 5,322,901	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,504,680	$ 175,861		$ 175,861	$	$ 5,322,901	1
2	HVAC	2003	11,370	1,137	10	1,137		1,706	2
3	Plumbing	2003	11,833	1,183	10	1,183		1,775	3
4	Oven repairs	2003	3,020	302	10	302		453	4
5	Dishwasher repairs	2003	1,419	142	10	142		213	5
6	Garbage disposal	2003	2,429	243	10	243		364	6
7	Freezer doors	2003	5,610	561	10	561		842	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		3,284	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		1,986	9
10	Washing machine repair	2003	1,045	105	10	105		157	10
11	Site improvement	2003	8,252	825	10	825		1,238	11
12									12
13	Fire alarm system	2004	140,676	7,034	10	7,034		7,034	13
14	Water pipes replaced	2004	44,498	2,225	10	2,225		2,225	14
15	Structural work	2004	5,331	267	10	267		267	15
16	Windows	2004	29,590	1,480	10	1,480		1,480	16
17	Wall divider	2004	11,280	564	10	564		564	17
18	Front gate and posts	2004	8,025	401	10	401		401	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,824,190	$ 195,843		$ 195,843	$	$ 5,346,890	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,235,383	$ 123,538	$ 123,538	$	10	$ 1,163,759	71
72	Current Year Purchases	52,852	2,643	2,643		10	2,643	72
73	Fully Depreciated Assets	768,603					768,603	73
74								74
75	TOTALS	$ 2,056,838	$ 126,181	$ 126,181	$		$ 1,935,005	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,906,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 322,024	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 322,024	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,281,895	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 82,488 Description: See attached schedule 14a
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home
PROVIDER # 0014076
11/30/2004

Schedule 14a

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Helium tanks	816
Mattress rental	22,750
Respiratory therapy equipment	16,327
Dish machine	1,740
Resident lift	27,929
Other medical equipment	12,926
	82,488

See Accountants' Compilation Report

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a C3	hrs	$	294,510	$ 229,718	$	294,510	$ 229,718	1
2	Licensed Speech and Language Development Therapist	L 10a C3	hrs		143,798	112,162		143,798	112,162	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a C3	hrs		267,096	208,335		267,096	208,335	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescrpts				268,372		268,372	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory therapy	L10a, C2, C3			1,358	40,741	10,660	1,358	51,401	13
14	TOTAL			$	706,762	$ 590,956	$ 279,032	706,762	$ 869,988	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/01/2003 to 11/30/2004

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies	Total
Total		0	-	-	-

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	380,042	380,042	15
16	Equipment, at Historical Cost	2,045,959	2,056,838	16
17	Accumulated Depreciation (book methods)	(7,281,895)	(7,281,895)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,613,254	$ 1,624,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,613,254	$ 1,624,133	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 242,856	$ 242,856	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	853,266	853,266	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,096,122	$ 1,096,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,096,122	$ 1,096,122	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 517,132	$ 528,011	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,613,254	$ 1,624,133	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 758,860	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 758,860	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,792,329)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,792,329)	17
	B. Transfers (Itemize):		
18	**Interfund transfers**	1,550,601	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,550,601	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 517,132	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,592,018	1
2	Discounts and Allowances for all Levels	(334)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,591,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,190	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,190	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous income**	166	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 166	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,594,040	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,600,867	31
32	Health Care	8,263,205	32
33	General Administration	672,881	33
	B. Capital Expense		
34	Ownership	405,840	34
	C. Ancillary Expense		
35	Special Cost Centers	278,876	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,386,369	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,792,329)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,792,329)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,080	$ 73,091	$ 35.14	1
2	Assistant Director of Nursing	1,640	2,080	56,846	27.33	2
3	Registered Nurses	30,898	33,295	833,035	25.02	3
4	Licensed Practical Nurses	65,576	70,765	1,470,489	20.78	4
5	Nurse Aides & Orderlies	232,328	252,297	3,178,490	12.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,415	17,549	280,634	15.99	8
9	Activity Director	2,032	2,080	44,720	21.50	9
10	Activity Assistants	15,057	16,272	209,840	12.90	10
11	Social Service Workers	8,694	9,359	217,118	23.20	11
12	Dietician					12
13	Food Service Supervisor	7,646	8,320	167,398	20.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	45,361	47,314	504,735	10.67	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	65,659	71,861	792,778	11.03	18
19	Laundry	17,454	19,102	208,611	10.92	19
20	Administrator	1,960	2,080	76,392	36.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,176	21,409	336,803	15.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	530,864	575,863	$ 8,450,980 *	$ 14.68	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	380	$ 15,069	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	35	1,600	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	71	3,535	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Alzheimers Consultant	97	5,836	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	583	$ 29,640		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,364	$ 259,226	L10, C3	50
51	Licensed Practical Nurses	7,767	303,646	L10, C3	51
52	Nurse Aides	14,182	278,158	L10, C3	52
53	TOTAL (lines 50 - 52)	27,313	$ 841,030		53

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Sorbero	Administrator	0	$ 76,392
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,392

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 21,436
UHC/Accumed Systems	Computer	2,995
Health Data Systems In	Computer	14,298
Altschuler Melvoin&Glasser, LLP	Accounting	9,750
American Express Tax & Bus Svce	Accounting	13,923
Medworks Hlth Services	Drug Screening	5,875
St Joseph's Hospital	Medical Billing	340
Momentus Health Info	Computer	550
Joliet Fed. Of Musicians	Music	2,780
Mutual of Omaha	Medicare Billing	3,856
Centerpoint Institute	Logo redesign	900
See attached Schedule 21a		1,335
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 78,038

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 346,486
Unemployment Compensation Insurance	
FICA Taxes	650,802
Employee Health Insurance	1,904,698
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	757,165
Uniforms	59,580
Employee morale	176
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,718,907

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,945
Health Care Worker Background Check	
(Indicate # of checks performed 109)	1,301
County Nursing Home Assn dues	2,670
Illinois Health Care Assn	11,880
Dues and subscriptions	3,649
MW Automated Time System license	1,035
Less: Public Relations Expense	(195)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,285

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/01/2003 to 11/30/2004 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Subtotal		78,038
Medi Inc	Medical billing	416
Medifax-EDI Inc	Medical billing	919
Total (agree to Schedule V, line 19, column 3)		79,373
Allocated from Will County		586,578
Total (agree to Schedule V, line 19, column 8)		665,951

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8	N/A												
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2003 Ending: 11/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $11,880; County NH Assn $ 2,670**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **180,694** Line **L10, C2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,190**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wermer, Rogers, Daran & Ryan** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is not complete.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	672,133	0	15,069	687,202	0	687,202	0	687,202
2. Food Purchase	0	500,662	0	500,662	0	500,662	-2,190	498,472
3. Housekeeping	1,001,389	75,863	0	1,077,252	0	1,077,252	-208,611	868,641
4. Laundry	0	0	25,913	25,913	0	25,913	208,611	234,524
5. Heat and Other Utilities	0	0	213,520	213,520	0	213,520	0	213,520
6. Maintenance	0	183	96,135	96,318	0	96,318	504,100	600,418
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,673,522	576,708	350,637	2,600,867	0	2,600,867	501,910	3,102,777
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	5,892,585	441,725	852,066	7,186,376	0	7,186,376	0	7,186,376
10a. Therapy	0	10,660	594,491	605,151	0	605,151	0	605,151
11. Activities	254,560	0	0	254,560	0	254,560	0	254,560
12. Social Services	217,118	0	0	217,118	0	217,118	0	217,118
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	6,364,263	452,385	1,446,557	8,263,205	0	8,263,205	0	8,263,205
17. Administrative	76,392	0	0	76,392	0	76,392	0	76,392
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	78,038	78,038	0	78,038	586,578	664,616
20. Fees, Subscriptions & Promotion	0	0	25,480	25,480	0	25,480	-195	25,285
21. Clerical & General Office	336,803	17,435	35,816	390,054	0	390,054	22,640	412,694
22. Employee Benefits & Payroll	0	0	98,330	98,330	0	98,330	3,620,577	3,718,907
23. Inservice Training & Education	0	0	3,229	3,229	0	3,229	0	3,229
24. Travel and Seminar	0	0	423	423	0	423	0	423
25. Other Admin. Staff Trans	0	0	935	935	0	935	0	935
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	360,292	360,292
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	413,195	17,435	242,251	672,881	0	672,881	4,589,892	5,262,773
29. Total General Administrative	8,450,980	1,046,528	2,039,445	11,536,953	0	11,536,953	5,091,802	16,628,755
30. Depreciation	0	0	322,024	322,024	0	322,024	0	322,024
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,328	1,328	0	1,328	-1,328	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	82,488	82,488	0	82,488	0	82,488
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	405,840	405,840	0	405,840	-1,328	404,512
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	268,372	10,504	278,876	0	278,876	0	278,876
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	164,700	164,700	0	164,700	0	164,700
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	268,372	175,204	443,576	0	443,576	0	443,576
45. Grand Total	8,450,980	1,314,900	2,620,489	12,386,369	0	12,386,369	5,090,474	17,476,843

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	0	0
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	0	0
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,000	25,000
14. Buildings, at Historical Cost	6,444,148	6,444,148
15. Leasehold Improvements, Historical Cost	380,042	380,042
16. Equipment, at Historical Cost	2,045,959	2,056,838
17. Accumulated Depreciation (book methods)	-7,281,895	-7,281,895
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,613,254	1,624,133
25. Total Assets	1,613,254	1,624,133
CURRENT LIABILITIES		
26. Accounts Payable	242,856	242,856
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	853,266	853,266
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,096,122	1,096,122
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	1,096,122	1,096,122
47.Total Equity	517,132	528,011
48.Total Liabilities and Equity	1,613,254	1,624,133

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,592,018
2. Discounts and Allowances for all Levels	-334
Subtotal - Inpatient Care	10,591,684
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,190
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	2,190
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	166
Subtotal - Other Revenue	166
30. Total Revenue	10,594,040
31. General Services	2,600,867
32. Health Care	8,263,205
33. General Administration	672,881
34. Ownership	405,840
35. Special Cost Centers	278,876
35. Provider Participation Fee	164,700
37. Other	0
40. Total Expenses	12,386,369
41. Income Before Income Taxes	-1,792,329
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,792,329

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